Alabama Heart and Vascular Medicine

Authorization to Release or to Obtain Medical Information

Fax (205) 345-4921

Patient Name (print): _____ DOB: _____/_____/_____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

I, the undersigned, authorize and request **Alabama Heart and Vascular Medicine to ____ release or to ____ obtain medical information from the following:**

Physician/Organization/Individual(s): _____
Address: _____Phone:_____ Fax: _____

_____ DCH Regional Medical Center or Northport Medical Center, 809 University Blvd., Tuscaloosa or 2700 Hospital Drive, Northport, AL, 205-759-7111 or 205-333-4500

Or other Hospital(s):_____
Address: _____ Phone:_____ Fax: _____

Please identify the information to be released/obtained:

___ Complete Record
___ *Lab Results (specify)* _____
___ *X-Ray/Imaging (specify)* _____
___ *Other (specify)* _____

The identified information will be used for the following purposes:

____ Sharing with my other healthcare providers
____ *For my personal records*
____ *Moving*
____ *Other (specify)* _____

Please initial each item below to indicate your understanding:

_____ I understand the information in my health record may include information relating to STD's, AIDS, or HIV. It may also include information relating to behavioral or mental health services, and treatment for drug and alcohol abuse.

_____ When my information is used or disclosed pursuant this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time in writing and understand my revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

Patient Signature: _____ Date: _____/_____/_____

Relationship to Patient: _____ Parent, _____ Legal Guardian, ____ Other (please specifiy) _____

Witness Signature: _____ Date: _____/_____/_____

This authorization will expire on (insert date or event): _____

If I do not specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.